Janice Chia

From: Fiona Hawthorne <Fiona.Hawthorne@health.qld.gov.au>
Sent: Wednesday, 1 October 2014 5:04 PM
To: Heidi Carr
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Yes. The stillbirth may have occurred due to factors beyond the system or clinician's control. This may be as a result of a medical conditions that occur during delivery such as placental abruption or infarct or cord constriction, to name a few. F

From: Heidi Carr [mailto:Heidi.Carr@justice.qld.gov.au]
Sent: Wednesday, 1 October 2014 4:48 PM
To: Fiona Hawthorne
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Hopefully one last question...when you say 'The challenge with stillbirth is that it is very complex and can occur as a result of unpredictable patient and/or fetal factors, nor as a result of clinician error' are you indicating this as the difficulty encountered with any form of review of stillbirths, and this means a review may not uncover systemic, facility-specific or practitioner-specific factors?

Thanks,
Heidi

Heidi Carr
Policy Advisor
Strategic Policy
Department of Justice and Attorney-General
Ph: 3239 6878

From: Fiona Hawthorne [mailto:Fiona.Hawthorne@health.qld.gov.au]
Sent: Wednesday, 1 October 2014 4:25 PM
To: Heidi Carr
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Hmmm. Both are internal to QH, but the RCA etc are conducted by the HHS with an expectation that the report is completed within 90 calendar days. The HHS-generated reports are not released to the public and may be released to the family if the commissioning authority approves it. The expert committees such as the QMPQC report to the public once every 12 months, but do not address individual cases as they have a statewide focus.

Happy to keep chatting, F

From: Heidi Carr [mailto:Heidi.Carr@justice.qld.gov.au]
Sent: Wednesday, 1 October 2014 4:16 PM
To: Fiona Hawthorne
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

That's great. Thank you so much Fiona.

I certainly appreciate its complexity. I am attempting to simplify it, but want to ensure the information is still accurate. Would it be better to differentiate between RCAs etc and the specialist committees on the basis that the former are internal review mechanisms and the committees are external? Or simply list them all as review mechanisms?

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NP_R

Regards,
Heidi

Heidi Carr
Policy Advisor
Strategic Policy
Department of Justice and Attorney-General
Ph: 3239 6878

From: Fiona Hawthorne [mailto:Fiona.Hawthorne@health.qld.gov.au]
Sent: Wednesday, 1 October 2014 3:47 PM
To: Heidi Carr
Cc: Erin Finn
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Hi Heidi,

No problem at all. This is a complex issue to navigate around.

I'll answer your questions in-text below:

Essentially, I have outlined that there are a range of options available to review individual adverse clinical incidents including – RCA, HEAPS, morbidity and mortality meetings and case reviews. There are then specialist review committees who also look at systemic issues with respect to maternal and perinatal mortality, including stillbirths – local perinatal mortality committees and the QMPQC.
It's not technically correct to differentiate between RCAs etc and the specialist committees as they both have a system focus. It is part of QH culture that we do not look to apportion individual blame. If a blameworthy act is found during the course of the investigation, then there are other steps to take.

I have then discussed any issues with the current mechanisms. However, currently this only includes the issues we discussed regarding HHS being able to decide how they wish to analyse adverse clinical incidents (so none of the review mechanisms are mandatory? Correct), stillbirths not meeting the definition of reportable event under the HHB Act for the purpose of RCA, the need for RCA to be specifically commissioned for stillbirths as a result and that operationally this is unlikely to occur.
A form of review is mandatory. Which methodology is chosen is up to HHS.

I was just wondering whether you would be able to briefly indicate what each of the review mechanisms are (other than RCA) and in particular whether there are any issues with the other mechanisms for stillbirths? Also, if any of the above is incorrect, please do let me know.
HEAPS (Human Error and Patient Safety) is a methodology that reviews an incident under various headings to trigger a more detailed review. Issues addressed include patient factors; task factors; practitioner factors, along with environment, equipment to give the reviewer a more in-depth appreciation for the context and circumstances of the event.
Morbidity & Mortality reviews are formal meetings undertaken at a unit or discipline level by a group of clinicians associated with the care of the patient. These are usually held monthly.
Case reviews are often undertaken by an individual clinician (usually of some seniority) to ascertain if the care provided met established standards.
None of the above have privilege. The challenge with stillbirth is that it is very complex and can occur as a result of unpredictable patient and/or fetal factors, nor as a result of clinician error.

I am at training Tuesday to Thursday next week, but my manager Erin Finn (who has been cc'd into this email) is available to answer any further questions you may have. Thanks, Fiona

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From: Heidi Carr [mailto:Heidi.Carr@justice.qld.gov.au]
Sent: Wednesday, 1 October 2014 12:08 PM

NP_R

To: Fiona Hawthorne
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Hi Fiona,

I apologise for bothering you again, but I just wanted to clarify my understanding of a number points for my policy submission.

Essentially, I have outlined that there are a range of options available to review individual adverse clinical incidents including – RCA, HEAPS, morbidity and mortality meetings and case reviews. There are then specialist review committees who look at systemic issues with respect to maternal and perinatal mortality, including stillbirths – local perinatal mortality committees and the QMPQC.

I have then discussed any issues with the current mechanisms. However, currently this only includes the issues we discussed regarding HHS being able to decide how they wish to analyse adverse clinical incidents (so none of the review mechanisms are mandatory?), stillbirths not meeting the definition of reportable event under the HHB Act for the purpose of RCA, the need for RCA to be specifically commissioned for stillbirths as a result and that operationally this is unlikely to occur.

I was just wondering whether you would be able to briefly indicate what each of the review mechanisms are (other than RCA) and in particular whether there are any issues with the other mechanisms for stillbirths? Also, if any of the above is incorrect, please do let me know.

Happy to discuss over the phone if you prefer, however, I thought I'd email first before bombarding you with questions.

Thanks again for all of your assistance with this, much appreciated.

Kind regards,

Heidi Carr
Policy Advisor
Strategic Policy
Department of Justice and Attorney-General
Ph: 3239 6878

From: Fiona Hawthorne [mailto:Fiona.Hawthorne@health.qld.gov.au]
Sent: Thursday, 25 September 2014 4:42 PM
To: Heidi Carr
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Hi Heidi,

I'll answer your questions below:

1. Are you able to advise whether consideration has been or will be given to reinstating RCA's as a central requirement where there is concern with the obstetric or perinatal care provided? The current Health Service Directive does not prescribe an RCA as a primary tool for the analysis for any adverse clinical incident. Each HHS is able to decide how they wish to analysis these incidents. RCA is one tool for the analysis of adverse clinical incidents. There are a number of others: HEAPS, morbidity & mortality meetings, case reviews amongst others.
2. Also, I note there was an internal review/investigation following the Rockhampton case. Are you able to advise whether the outcome is part of the reason for the issues paper? No, the issues paper was in development prior to the Rockhampton case.
3. In addition, are you able to provide me with further information regarding the RCA process in the context of stillbirths or direct me to where I can locate this information? The challenge with stillbirth is that it does not

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meet the definition of a reportable event under the *Hospital and Health Boards Act 2011*, therefore any RCA commissioned for a stillbirth does not attract privilege. I'm happy to chat this bit through. It can be a bit wordy for an email.

We also have the Qld Maternal & Perinatal Quality Council which reports to the Queensland Health Minister, and has a quality agenda which encompasses both public and private sectors. It is a gazetted quality committee under Part 6, Sections 81 - 92 (Quality Assurance Committees) of the *Hospital and Health Boards Act 2011*. Membership includes representation from neonatology, obstetrics, midwifery, neonatal nursing, specialist obstetrics/maternal fetal medicine, general practice obstetrics, Indigenous health, academic/research, consumer representation.

I have attached the section from their latest report for you to review. The link for the full report is:
http://www.health.qld.gov.au/caru/networks/qmpqc_publications.asp

The QMPQC's purposes are to:
Collect and analyse clinical information regarding maternal and perinatal mortality and morbidity in Queensland to identify state-wide and facility-specific trends
Make recommendations to the Minister for Health on standards and quality indicators of maternal and perinatal clinical care to enable health providers in Queensland to improve safety and quality
Assist with the adoption of such standards in both public and private sectors

Let me know if you need any further information or want to have a chat about RCA and stillbirths.

Thanks, Fiona

From: Heidi Carr [mailto:Heidi.Carr@justice.qld.gov.au]
Sent: Thursday, 18 September 2014 4:41 PM
To: Fiona Hawthorne
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Hi Fiona,

Thank you very much for your response.

Further to the information provided, are you able to advise whether consideration has been or will be given to reinstating RCA's as a central requirement where there is concern with the obstetric or perinatal care provided? Also, I note there was an internal review/investigation following the Rockhampton case. Are you able to advise whether the outcome is part of the reason for the issues paper?

In addition, are you able to provide me with further information regarding the RCA process in the context of stillbirths or direct me to where I can locate this information?

If you are not in a position to respond to the above, can you please advise who might be the appropriate person to direct my questions?

Kind regards,

Heidi Carr
Policy Advisor
Strategic Policy
Department of Justice and Attorney-General
Ph: 3239 6878

From: Fiona Hawthorne [mailto:Fiona.Hawthorne@health.qld.gov.au]
Sent: Thursday, 18 September 2014 4:07 PM
To: Heidi Carr

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NP_R

Cc: Erin Finn
Subject: RE: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Hello Heidi,

Thank you for your email. Unfortunately we have not yet been able to significantly progress the review of existing mechanisms to review stillbirths in the public health system. We have drafted an issues paper to canvass support to strengthen legislation to remove any doubt that intrapartum stillbirths can be the subject of legally protected root cause analysis. We hope to be able to finalise that paper for stakeholder consultation next month. I'm not sure of any additional role for the Health Ombudsman and would suggest that would be best discussed directly with them.

Kind regards, Fiona

Fiona Hawthorne PhD, Churchill Fellow
Principal Project Officer
Patient Safety Unit | Health Systems Innovation Branch | Health Service and Clinical Innovation Division
Department of Health | Queensland Government
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e. fiona.hawthorne@health.qld.gov.au | www.health.qld.gov.au

Great state. Great opportunity.

From: Heidi Carr [mailto:Heidi.Carr@justice.qld.gov.au]
Sent: Monday, 15 September 2014 4:59 PM
To: Fiona Hawthorne
Subject: Possible amendments to the Coroners Act 2003 regarding the investigation of stillbirths

Dear Fiona,

I am the officer within the Strategic Policy and Legal Services division of the Department of Justice and Attorney-General who is currently considering possible amendments to the *Coroners Act 2003* regarding the investigation of stillbirths. As you may recall, Amber Manwaring was previously responsible for this matter.

NP_Sch3(2)(1)(b)

I note that the Honourable Lawrence Springborg MP provided a submission dated 13 August 2013 in relation to this matter, and I just wanted to ascertain what, if anything, has changed or improved since such time, and in addition to the previous mechanisms outlined, whether there is an additional role for the Health Ombudsman regarding the investigation of stillbirths.

Kind regards,

Heidi Carr

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Policy Advisor
Strategic Policy
Department of Justice and Attorney-General
Ph: 3239 6878

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